How to Report Workers' Compensation Injuries

Incident Reporting Procedures
Employee Work-Related Injuries

In life-threatening situations, immediately seek medical assistance, then complete these claim forms!

To ensure the safety and well-being of our employees, we request your help in reporting work-related injuries and illnesses as soon as possible. This allows prompt medical attention as well as the correction of any existing hazardous conditions.

How Are Injuries Reported?

- ☐ Injured worker notifies supervisor.
- ☐ Together, the Supervisor **and** Injured worker immediately call the Company Nurse Injury Hotline: 1-888-770-0925.
- ☐ Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment with an approved panel of physicians. ***(Failure to go to an approved physician on the panel may result in your bill being denied.)***

Workers' Compensation claims are administered and adjusted by a third party administrator. Employees should report all work-related injuries/illnesses to their supervisor within **24 hours of injury**.

Supervisors Responsibilities Checklist

Make sure the following forms are completed:

- ☐ **Supervisor's Investigation Report** – Obtain a detailed description of the accident, as well as a specific place and time at which the injury occurred. Provide pictures of area where injury occurred if applicable.
- ☐ Fax the **Supervisor's Investigation Report and Doctor's Note** to the HR Office @ 540-422-8318 or email to riskmanagement@fauquiercounty.gov.
- ☐ If the employee seeks medical treatment, HR **must** receive a Return to Work Note **prior** to their planned date of return. Preferably 48 hours prior to return if released with restrictions to allow for review.

Failure to report such activities may affect benefits from workers' compensation.

If you have any questions, please feel free to contact the HR Office at (540) 422-8300.

IN CASE OF WORKPLACE INJURY:

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE

Injury Hotline

1-888-770-0925

AVAILABLE 24 HOURS A DAY

1. Injured worker notifies supervisor.
   Empleado lesionado notifica a su supervisor.

2. Supervisor and Injured worker immediately call injury hotline.
   Supervisor y Empleado lesionado llaman inmediatamente a la línea de enfermeros/as.

3. Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.
   Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

EMPLOYER NAME (NOMBRE DE COMPANIA)	*SEARCH CODE (CÓDIGO DEL BÚSQUEDA)*
Fauquier County Public Schools	V030B

Notice to Employer/Supervisor:

Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.

Visit us online: www.CompanyNurse.com

SUPERVISOR'S INVESTIGATION REPORT

Employee's Name | Department | Job Title | How Long on Job

Date of Injury/Illness | Time | Location | Body part injured

What happened?

Root Cause Analysis - *Check ALL that apply to this accident*			
Unsafe Act(s)		Unsafe Condition(s)	
Improper work technique		Poor Workstation design	
Safety rule violation		Unsafe Operation Method	
Improper PPE or PPE not used		Improper Maintenance	
Operating without authority		Lack of direct supervision	
Failure to warn or secure		Insufficient Training	
Operating at improper speeds		Lack of experience	
By-passing safety devices		Insufficient knowledge of job	
Protective equipment not in use		Slippery conditions	
Improper loading or placement		Excessive noise	
Improper lifting		Inadequate guarding of hazards	
Servicing machinery in motion		Defective tools/equipment	
Horseplay		Poor housekeeping	
Drug or alcohol use		Insufficient lighting	

What are the contributing factors to the root cause of the accident?

What should be done to prevent a future similar injury/illness?

Who will initiate the above corrective action?

Do you agree with the employee's statements on the Official Occupational Injury/Illness Report? Yes/No (circle one)

Comments: _____

Supervisor Signature _____ Date_____

PHYSICAL CAPABILITIES FORM

Name: _____ Injury Date: _____ Age: _____

Employer _____ Department/School _____

Injury/Complaint(s) _____

Diagnosis _____

Is complaint(s)/Diagnosis work related? Yes ☐ No ☐

In an eight hour day, the patient can (please circle full capacity for each activity and check appropriate box)

		With Restrictions	Continuously	Comments
Stand	1 2 3 4 5 6 7 8 Hrs.	☐	☐	
Walk	1 2 3 4 5 6 7 8 Hrs.	☐	☐	
Sit	1 2 3 4 5 6 7 8 Hrs.	☐	☐	

In an eight-hour day, the patient can:

Lift up to	Never	Occasionally 0-33%	Frequently 34%-66%	Continuously 67%-100%
10 Lbs.	☐	☐	☐	☐
20	☐	☐	☐	☐
50	☐	☐	☐	☐
100	☐	☐	☐	☐
Carry up to:				
10 Lbs.	☐	☐	☐	☐
20	☐	☐	☐	☐
50	☐	☐	☐	☐
100	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Patient can use hands for repetitive actions such as:

Simple Grasping Yes ☐ No ☐ Pushing/Pulling Yes ☐ No ☐ Fine Manipulation Yes ☐ No ☐

Patient can use feet for repetitive movements as in operating foot controls

Right foot Yes ☐ No ☐ Left foot Yes ☐ No ☐ Both Yes ☐ No ☐

Patient is restricted by environmental factors (heat/cold, dust, dampness, heights, fumes, gas, etc.)

No restrictions ☐ Limited restrictions (please specify below) ☐

If position requires, Patient can fully and safely operate vehicle without accompaniment Yes ☐ No ☐

Patient can return to work on this date: ___/___/___ and can assume: Full duty ☐ Modified duty ☐

If modified duty, patient can return to full duty on (estimate date): ___/___/___

Modified duty restrictions: _____

Medication prescribed: _____

Does medication prevent patient from working on or around equipment, machinery, or driving? Yes ☐ No ☐

If answer is "yes", explain: _____

Date of follow up appointment ___/___/___ If referred, physician's name _____

Will patient require any assertive devices or braces to return to work Yes (specify below) ☐ No ☐

Describe assertive devices needed, and restrictions they may cause: _____

Other comments: _____

Physician's name(please print): _____ Telephone Number: _____

Physician's signature: _____ Date: ___/___/___

Please send all bills to The Human Resources Department, 320 Hospital Drive, Suite 34, Warrenton, VA. 20186 Attention: Risk Management

Workers' Compensation Temporary Prescription ID Card

VACORP

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury
(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

Group #: M5L2017

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

ACCREDO HEALTH GROUP

BECKLEY ARH PHARMACY

BLOOM PHARMACY

BOARDWATER DRUG BY WAGS

CAREPOINT PARTNERS

CONTINUUMCARE PHARMACY

COSTCO

CRITICAL CARE SYSTEMS

CVS

DULLES URGENT CARE CENTER

EMERGENCY PHYS IMMEDIATE CARE

ER PHYSICIANS IMMEDIATE CARE

EXTENDED CARE ASSOCIATES

FARM FRESH PHARMACY

FOOD LION PHARMACY

GIANT DISCOUNT DRUG

GIANT EAGLE

GIANT PHARMACY

HARRIS TETTER PHARMACY

HOME CARE PHARMACY

JEFFERSON URGENT CARE

KAISER PERMANENTE PHCY

KMART PHARMACY

KROGER PHARMACY

MARTINS PHARMACY

MARTIN'S PHARMACY

NEIGHBORCARE PHARMACY

PATIENT FIRST

PHARMERICA

PROGRESS PHARMACY SERVICES

RICHMOND SOUTHSIDE TRTMNT CNTR

RICHMOND TREATMENT CENTER

RITE AID

RX SERVICE

SAFEWAY PHARMACY

SAMS

SAM'S CLUB

SHOPPERS PHARMACY

SHOPPERS PHARMACY #978

STERLING AUTOMATED REFILL CNTR

TARGET PHARMACY

UKROP'S PHARMACY

WALGREEN'S

WAL-MART

WEGMANS FOOD MARKETS

WEGMANS PHARMACY

WEIS PHARMACY

WILLIAMSONS PHARMACY